SCOTTISH HOME AND HEALTH DEPARTMENT

The Organisation of a Medical Advisory Structure

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Joint Working Party on the
Integration of Medical Work

Report of a Sub-group on
Medical Organisation

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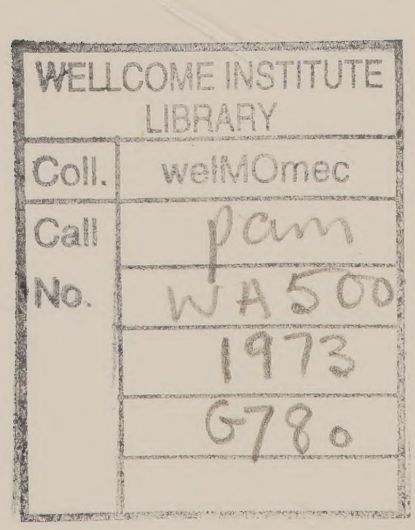
This Report, prepared by a working party of doctors set up by the Secretary of State for Scotland, is published as a basis for further study of the questions with which it deals. The medical profession, the health authorities and the Government are not in any way committed by its recommendations.



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Preface

The Joint Working Party was appointed by the Secretary of State for Scotland in December 1969. In anticipation of reorganisation of the health service its first task was to produce an analysis of the opportunities which would arise from the integration of medical work for improving our arrangements for medical care. The result was the publication in 1971 of the report entitled *Doctors in an Integrated Health Service* which has stimulated continuing discussion on important issues which affect everyone concerned with health care in Scotland.

The report indicated that further studies would be necessary and for this purpose, in November 1971, the Joint Working Party appointed four Sub-groups, each comprising some members of the Joint Working Party itself with additional members co-opted to reflect different professional backgrounds and experience. It was the remit of one of those Sub-groups to study and make recommendations on Medical Organisation. Their report *The Organisation of a Medical Advisory Structure* is now published as one of a series of studies by the Joint Working Party arising from its first report.

JOHN BROTHERSTON
Chairman of Joint Working Party

Foreword

The practice of medicine is a practice of care; the running of a health service is a practice of organisation. These are two systems with a shared objective, but they show wide differences of background and are in contrast in the way in which their respective skills are deployed.

Care, whether it is directed towards individual patients or whole communities, whether it looks towards today's needs or towards the future, commits the doctor directly and inescapably. His basic skill—and his highest—is to harness his knowledge to a personal accountability for the welfare of those in his charge, and it is this skill which a health service exists to encourage and to make widely available. Unlike almost any other organisation, therefore, a health service has the majority of its most responsible personnel at its periphery, and not at its organisational centre.

Its internal structure, however, is like that of any other large organisation. Administratively speaking, it has a centre or centres of maximum responsibility where high levels of skill in management are needed, and where accountability for the control of very large resources is concentrated. The problem that faces the health professions and health service administrators—and not only in the United Kingdom—is to use machinery of this sort, which is inevitably centrally orientated, to sustain myriads of wholly independent medical decisions widely dispersed throughout the country. It is within this perspective that we should wish our present work to be viewed and judged.

Clinicians are not by nature managers, managers are not doctors, and this report is not attached to any idea of merging the two groups in some new medico-managerial utopia. On the contrary, its implications are for the heightening of the professional awareness of both groups, given always that it is foremost in all discussions that two different forms of efficiency have each to be pursued with equal zeal if the common objective of a first class health service is to be realised. If a change in medical thinking is needed, it is towards accepting as normal that the practice of medicine increasingly requires an organisational framework, not as a result of legislative action but simply because the resources that are needed are so large. These cannot be created without planning, and cannot be maintained without effective systems of accounting and management. The contribution that high managerial standards can make to patient care requires to be more widely recognised. Management itself, by the same token may perhaps take the present opportunity to acknowledge that

close involvement with medical opinion is essential to its activities, and that the fullest possible partnership is needed in all policy decisions that affect the provision of facilities for the care of patients.

In the context of the general re-appraisal that the new legislation will produce, this report is no more than a means of focussing attention on one aspect in a wider area of change. None the less, it is an important aspect, that deserves well informed discussion. It has been part of our responsibility to try to ensure as far as we can that discussion is objectively based, and that reasons and conclusions are clearly stated; we have aimed, therefore, at writing as simply and directly as a complicated subject allows.

There are none the less some complexities of expression, and some sources of possible misapprehension that require mention. 'Discipline', for example, has been used to refer in some reports to the whole field of activity of one profession, and in others to individual fields within a profession; 'multi-disciplinary committees' has therefore had two quite different meanings. We hope that 'multi-professional', although not notably elegant, is at least explicit. Of rather more potential danger are words that are satisfactory in one context but not in another. It is both accurate and acceptable to talk of levels of administration, but misguided to do so in circumstances that allow a mistaken association of ideas to relate this, however remotely, to levels of clinical decision. Area medical committees will have a wider influence than district medical committees, and the two will operate at different administrative levels; but the difference in their activities is not capable of expression in hierarchical terms, and we have thought it incorrect therefore to use expressions such as 'district level'.

There remain words in the use of which some possibility of misinterpretation has to be accepted because the alternative is a lengthy circumlocution, frequently repeated. 'Central' and 'peripheral' have connotations of 'more important' and 'less important'. Where the weight of managerial responsibility, or of corporate medical advice is concerned, this is correct. But we hope it will be clear from the general tenor of the report that 'the centre' is not central in any sense that concerns clinical responsibility, and that 'the periphery' is the administrative point that is closest to it.

Where 'national' is used, the reference is to Scotland.

N. G. C. Hendry
Chairman of Sub Group

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Chapter 1 **Introduction**

1.1 The National Health Service (Scotland) Act 1972 is expected to come into full force on 1 April 1974. The aim of the Act is to improve standards of health care by whatever changes are made possible by integration of the hitherto administratively separate three branches of the service. The keystone of this integration is the establishment of 15 Health Boards which will be responsible each in its own area for the provision of primary care, hospital services and community medicine. The Act also envisages the establishment of professional committees which Boards will have a duty to consult and from which they will be expected to receive advice. The range of activity of these committees will run from relatively routine matters to advising on major developments in the planning of services and the allocation of resources, and from purely local responsibilities up to those affecting the whole of Scotland.

1.2 Health Boards are likely to be set up shortly in 'shadow' form so that they can begin to undertake the necessary forward planning for the assumption of their full responsibility on the Act's vesting day. For that purpose they will require advice from medical committees representative of the whole profession, set up under the terms of the Act. There is need therefore for these committees also to be brought into existence at the earliest possible date.

1.3 The significance of the forthcoming change should not be underestimated. The terms of the Act, and the discussions that have surrounded it, make it clear that this is to be no mere adaptation of the existing administrative structure. What is involved is its total replacement by a new management structure in which executive authority and professional advisory machinery must interlock in partnership. The new arrangement gives the profession an opportunity to influence and guide the administration of the service and, in our view, lays upon it a positive duty to do so. The profession will be expected on the basis of its specialised knowledge and of its appraisal of existing services to initiate proposals and to influence policy at all levels.

1.4 If this opportunity is to be seized and used to the greatest advantage of the public and the profession as a whole, initiative is required of the profession now. A series of professional committees should be set up, within districts and areas, and nationally, with the responsibility of ensuring that policy in the health service reflects as clearly as possible the attitudes and values that underlie the practice of medicine, and which medicine shares with its related professions. Only in this way can the

ideas, interests, and expert knowledge of each doctor contribute in the highest degree to the health care of the population.

1.5 The consultative machinery required to meet this responsibility should be called the Medical Advisory Structure (MAS). This report consists of an examination of the general principles on which the MAS might best be set up, and proposes a broad framework.

Chapter 2 **The Reorganisation of the Scottish Health Services**

2.1 This Chapter is not intended as a full explanation of the current proposals for the reorganisation of the health service but as a background to fuller consideration of the Medical Advisory Structure, particular emphasis being given to those points which are of special relevance to the MAS.

2.2 The Health Boards which will be established will be in direct relationship with the Scottish Home and Health Department, and finance will be allocated to each to meet the responsibility for the maintenance and development of an integrated health service. The Health Board will be the employer of staff in its area and will be the authority with which general practitioners will have a contractual relationship.

2.3 There are likely to be 15 Health Boards and there will be considerable variation in the populations for which Boards will be responsible. If proposals in the White Paper (*Reorganisation of the Scottish Health Services* (Cmnd. 4734)) are followed, the maximum population will be 1,170,000 in Glasgow and the minimum population on the mainland of Scotland will be 96,000 in the Borders. The Health Boards for Orkney, Shetland and the Western Isles will be responsible for even smaller populations. The members of Boards will be appointed by the Secretary of State after consultation with interests concerned. Senior officers of the Boards, including the Chief Administrative Medical Officer, are expected to function as an executive group.

2.4 Except in areas with very small populations, there will be need for a subordinate management structure, and it is therefore probable that the majority of areas will be divided into two or more districts. There is no direct provision in the Act for a district management structure; the division of areas into districts and the management arrangements for these districts will emerge from the management plans of Health Boards. District management will be primarily concerned with the operation of the service rather than with major decisions on planning and policy, which will be matters for Health Boards to determine within their areas. The functions of district management will be essentially those of executive management; of arranging for the supply of health care to individual patients, to groups of patients and to the community; and of arranging for the provision of the supporting services which patients and health professional staff require. Within some districts, there will be a need for sub-division of management to take account of local circumstances and

the presence of existing institutions. It is expected that senior officers in district management, including a District Medical Officer, will operate as an executive group.

2.5 The central organisation will consist of

(*a*) The Scottish Health Service Planning Council, which will have a duty to advise the Secretary of State on the exercise of his functions under the Health Service Acts, whether at his request or on their own initiative. The Council will consist of a chairman appointed by the Secretary of State, one member appointed by each Health Board, one member appointed by each University with a medical school, not more than 6 officers of the Secretary of State and such other members as may be appointed by the Secretary of State.

(*b*) A Common Services Agency which will provide Health Boards and the Scottish Home and Health Department with the various executive and advisory services which are necessary throughout Scotland and which can be provided most efficiently by a single agency.

(*c*) The Scottish Home and Health Department.

2.6 Section 16 of the Act makes provision for professional advisory committees in relation to Health Boards. Where, after consultation with the Health Board concerned, the Secretary of State is satisfied that a committee formed for the area of the Board is representative of the medical practitioners of that area, he is to recognise that committee and it is to be called the Area Medical Committee. It will be the general function of a committee recognised under this section to advise the Health Board on the provision of services under the Health Service Acts in its area. In exercising their functions under the Health Service Acts, Health Boards are to consult with committees recognised under section 16 on such occasions and to such extent as may be prescribed.

2.7 Section 18 of the Act makes similar provision for the Secretary of State to recognise professional committees in relation to the central organisation of the health service. These committees will be known as National Consultative Committees, and their general function will be to advise the Scottish Health Service Planning Council on the provision of services under the Health Service Acts. The Planning Council is to consult with these committees on such occasions and to such extent as may be prescribed.

2.8 These two sections of the Act, *viz* sections 16 and 18, provide the framework within which the necessary partnership between the professions and the management structure of the Health Service can be formed. It is important for the medical profession to realise that while these two sections enable the Secretary of State to recognise professional committees, the responsibility for the formation of these committees rests with the professions themselves.

Chapter 3 **The Medical Advisory Structure: General Principles**

3.1 The potential improvement in patient care that could result from administrative reorganisation will be realised only if two fundamental principles are observed. One is that professional opinion and advice must be firmly based on the realities of patient care, the other that this advice must be clearly transmitted to those whose responsibility it is to make policy. The success of the administrative arrangements will depend on professional initiative being exercised and corporate professional advice being presented in the most authoritative way to Boards and other executive bodies through linked committees acting within the service as an integral part of it.

3.2 The characteristics required of the Medical Advisory Structure are therefore

a that it should be able to provide considered advice to management;

b that there should be clearly defined lines of communication so that every doctor may become involved in the advisory process and participate in it with full knowledge and understanding;

c that it should have access to information and the capacity to interpret it so that all doctors can take an active part in the analysis of the effectiveness of the health service and of their own contribution to it;

d that it should be able to establish close liaison with the nursing profession and all others concerned with the care of patients.

3.3 Since there is so pressing a need for the emergence of an agreed view from the profession and the creation of an agreed structure we think it may be helpful here to identify the following areas which we ourselves found it necessary to discuss and upon which we found agreement.

i The MAS should consist of doctors acting together in the interests of patient care. It should reflect both their individual expertise and their contribution to team work.

ii The MAS should involve every doctor working in the health service. The right and duty to participate should be automatic and should be seen as an enlargement of the existing responsibilities towards patients and communities.

iii The MAS should have close relationships with the other advisory structures which we look forward to seeing established by other health professions.

iv At every point where policy decisions affecting health care are taken there should be a corresponding focus of professional advice.

v The MAS will be an essential part of the health service. Servicing should be available from health service sources.

vi The MAS will be independent of the administrative structure in its derivation and in its choice of activity. It will not be part of the formal hierarchical management structure but should participate in whatever managerial decisions require professional advice. It should actively seek the development of a continuing partnership with management.

vii Community medicine is emerging as a specialty with a wide range of functions. One of these functions will be to facilitate communications between the MAS and formal management.

viii The MAS should have close links with all bodies concerned with clinical teaching and research. The arrangements should be such as to safeguard the continuing contribution of universities to the National Health Service.

3·4 The effectiveness of individual MAS committees and of the whole structure will depend greatly on the way in which the membership can be made to reflect accurately the very wide range of activities involved in medical care. It is in the interests alike of patients, of the community, and of the whole profession that advice from every field of practice should be clearly formulated and that claims on resources should be based upon the authoritative views of those actively concerned. It is of even greater importance however that the relative merits of competing claims should be assessed within the MAS itself and that the view that is put forward to management should be co-ordinated, responsible and realistic. The MAS will be required therefore to provide a channel of access to management, to express a corporate medical viewpoint, and to provide a general background of accepted medical priorities.

3·5 In an ideal situation, committee members might be found both in hospital and general practice who have a deep knowledge of their own field and sufficient contact with others for them to be able to represent both the particular and the general view with equal acceptance by their colleagues. We hope that, as experience with the new structure accumulates, this ideal will be more and more closely approached. Representation and communication will clearly be simpler in the future if the present trend continues for increased participation of general practitioners in hospital work and the corresponding participation of specialists in the work of the health centres. Committee size should always be the minimum that will ensure ease of communication with all constituents, and enjoy the confidence of the profession and of the administration that all necessary interests have their voice heard. Individual members of MAS committees will have the additional

responsibility of making themselves accessible to their colleagues as a means of ensuring the free flow of opinion between a committee and those whose views it represents.

3.6 For the present and for as long as sharp professional differentiations continue, the minimum size of committees may be larger than the ideal, and representation may have to be fairly rigidly laid down. Any committee structure within institutions such as hospitals or health centres should have a balance that represents the activity of the institution. Where, however, a committee represents the whole medical activity of a district or area and seeks formal recognition as such, it will have to be seen to involve all fields of practice equally and in particular to give the same weight to hospital and to general practice. Approximate equality of source of membership should therefore be the norm in all integrated committees.

3.7 In suggesting 'approximate' rather than 'exact' equality we have in mind that committees however fully their membership is integrated will probably wish to reflect to some extent the balance of medical activities in the geographical area which they serve. It should be clear too that a rigidly 'representational' concept is out of keeping in a body that should work by consensus. At the same time it must be obvious that any great disparity in the two main sources of membership will interfere severely with a committee's credibility. Where, therefore, representation on a directly proportional basis would result in a marked preponderance of doctors from one or other group, the committee itself or the minority group within it should seek to adjust the membership so that a satisfactory balance is produced.

3.8 If these or other similar general principles are found to be acceptable by the profession at large, there should be common ground throughout the country on the kind of basic structure appropriate to the MAS. Considerable flexibility of detail may however be necessary to meet local conditions and local opinion. In the constitution of committees allowance should be made for evolution to take account of changing conditions and to incorporate the results of experience.

Chapter 4 The Medical Advisory Structure in a District

4.1 At no point in the MAS will the need to adapt to particular conditions of practice loom as large as in the district structure. The problems resulting from this adaptation will require to be resolved locally and we do no more here than indicate the kind of basic concepts upon which we believe a sound district MAS can be constructed.

4.2 The shape of the district management structure will emerge from the management plans which Health Boards will be expected to prepare (see para 2.4) and it will be important to ensure that in any district the two structures (*ie* the MAS and the management structure) are sufficiently well matched to be able to function in co-operation with one another.

4.3 Wide variations will exist for example in the size and density of population, the size and complexity of hospitals and the presence or absence of health centres. In very populous areas containing large hospitals and health centres, a management sub-structure below that of the district itself is likely to be required. It follows from what has been said in Chapter 3 that in these circumstances the MAS also will require a sub-structure below its district medical advisory committee. As a general guide the essential in any district will be to ensure that the two structures—executive and medical advisory—are accurately matched and able to function in parallel with one another.

The Division as the basic unit of the MAS

4.4 Given that the term 'division' is still in a state of evolution we regard it as the only adequate description of the basic unit upon which the rest of the MAS should be constructed. The concept is a flexible one and experience has shown that it is capable of adapting to most variations of local circumstance. While it was originally put forward in the report of the Joint Working Party on the Organisation of Medical Work in the Hospital Service in Scotland* as applying to the hospital service, it should be possible to modify it in the light of experience to suit the requirements of all forms of practice in a reorganised Health Service.

4.5 The objectives in the formation of a division are to provide means whereby all the doctors working in the service can come together in suitable groupings to meet their obligations to organise clinical work, to improve standards of patient care, to assess and evaluate their own work

* *Organisation of Medical Work in the Hospital Service in Scotland* published by HMSO in 1967.

in relation to the needs of the community, and to provide soundly-based professional advice to management. There may well be common membership of some divisions especially as hospital and general practice move more closely together. Representatives of the other health care professions may share increasingly in meetings as a further contribution to integration.

4.6 If these objectives are kept in mind, then the division becomes the means by which doctors can organise their own work to best advantage, advise on local policy, and influence the deployment and use of the resources which a district has had allocated to it.

4.7 For general practitioners the new structure will present problems which cannot be solved by the simple extension of their existing institutions. The present organisational structure of general practice is less formal than that of hospitals and may require time to complete its evolution. Local Medical Committees have no structure below them and none above them except at national level. It is however vital to the quality of the service that general practitioners should enter fully into the Medical Advisory Structure so that hospital and general practice may contribute equally to the planning and management of the Health Service as a whole.

4.8 The formal organisational structure for general practice in the new service should be the grouping together of general practitioners with similar or complementary interests. Where health centres exist this will require little encouragement: where they do not exist there are already groups in being which act as electoral constituencies for Local Medical Committees. Initially these electoral constituencies could simply continue to function in this way in relation to the District Medical Committee but in the expectation of gradually assuming a more significant role. As the opportunities develop for a full involvement in decision-making within the district these groups would then, along with those from health centres, form the basis of a full divisional system in general practice.

4.9 Difficulties on the hospital side may be largely those of scale. Where a district contains several hospitals including large teaching and district hospitals there will be large numbers of medical staff, many of them working in highly specialised fields. Difficulties are to be anticipated in giving adequate weight to a wide range of specialty interests when they are incorporated into a relatively small number of divisions each with a large membership. This is none the less the correct form of organisation provided the divisions have an internal structure adapted to the working requirements of their members. In practice (and experience already points to this) groupings based on specialist interest will emerge within divisions as a natural development. Since the larger specialties are tending more and more to differentiate into a number of related areas of highly specialised interests there is value in developing a system which

gives the profession the proven advantages of large broadly-based divisions while ensuring also that the narrower interests can preserve their proper identity. There should be no situation in which a specialty is denied a voice simply because of the small number of doctors practising it.

4.10 Thus we foresee in populous districts a structure in which the name 'division' is reserved for large groupings covering broad fields of practice and possibly extending over several hospitals and a range of specialty interests. Within any of these divisions there could be functional groupings or departments which might in some instances be linked to similar groupings in another division. Divisions would be the functional units from the point of view of district management and all doctors would find a place in them and contribute to policy decisions through them. Doctors in the smaller specialties would play their part in contributing to divisional and district policies but could also have lines of communication which might include colleagues in other districts. In serving the particular interest of their own specialty, they might find it more convenient to communicate on an Area basis rather than with District Medical Committees. Their opinions would be subject in Area Medical Committee to the same co-ordinating process as would otherwise have occurred in the district.

4.11 At the other end of the scale there will be a few districts with small populations in which the hospital component of the Health Service is not large enough to justify the formation of a series of hospital-based divisions. In such circumstances a simpler form of organisation based on a committee of the whole medical staff might be appropriate.

The District Medical Committee

4.12 Hospital-based divisions have been used to an increasing extent over the last few years as the basis of the medical staff's approach to management. In the light of this experience it should not be difficult either as a concept or in practice to use these divisions as the source of the hospital part of the new District Medical Committee's membership.

4.13 General practice so far has no directly comparable experience to call on and the value and extent of its potential contribution requires specific mention. It covers a wide range of clinical activities and experience varying according to geographical location and the grouping of practitioners. Since the general practitioner is responsible for the vast majority of all medical episodes from start to finish, and for the admission and after-care of the remainder who require hospital treatment, he is well placed to interpret the health care needs of the community. If integration within the reorganised health service is to be successful this experience must find a place in its advisory structure in the district that is equal in numbers and in infl uence to that of other forms of practice.

4.14 Community medicine has the choice of being represented through its hierarchy or of making a corporate contribution as other specialties do. Whichever of these methods the specialty itself chooses, we would expect to see individual members of it closely involved in the work of divisions.

4.15 We see the District Medical Committee therefore as the point within the district at which medical opinion is co-ordinated and where all corporate advice on the medical aspects of the management of a district is determined. It might consist of the chairman or other representative of each hospital and general practice division joined by representatives of junior doctors. The Chairman of the Committee should be elected by the Committee itself and should be its usual spokesman. Neither he nor his Committee should however be the sole point of contact between the MAS and the executive and he should guide the officers of district management into consulting chairmen of divisions or other accepted representatives where appropriate. His greatest contribution may well arise from his developing a continuing relationship with senior officers in district management and his frequent attendance at their meetings.

District Medical Advisory Structure and the Universities

4.16 University staff with honorary appointments in the National Health Service will of course participate fully in the MAS within each district where there is a medical school. Special consideration must however be given to the implications which the creation of a district MAS may have for university clinical departments and for the medical schools as corporate bodies.

4.17 The universities should be assured that the facilities they need within the Health Service for the discharge of their responsibilities for teaching and research will continue to be available to them. The new arrangements should not impinge upon the responsibility of the head of a university department to allocate the resources at his disposal for university purposes.

4.18 There should be sufficient flexibility within divisional structures for university clinical departments to associate themselves in several ways and the relationship need not be a static one. A university clinical department will always have an academic identity, and its members may have common interests which enable it also to function as a clinical entity: but it may eventually be far more useful—even if more difficult—for its staff to participate in the clinical work of several functional groups within the division according to individual interests.

4.19 We regard it as essential that the university viewpoint should always be known to District Medical Committees and we would expect the normal processes within the divisional structure to ensure that this

was so. However, there may sometimes be a case for specific university representation in a District Medical Committee to supplement the arrangements under section 15 of the Act for the establishment of University Liaison Committees in areas.

Links between the Medical Advisory Structure and District Management

4.20 The relationship between the MAS and district management must be close and continuing. It would be insufficient to regard district management and the district MAS as two structures existing in parallel and communicating only from time to time, through formal channels. The two structures must be seen to work together closely and to have free communication with one another, much of it on a day-to-day and informal basis.

4.21 One member of the district executive group will be the District Medical Officer. In all but the smallest districts he would be assisted by other specialists in community medicine. Each specialist in community medicine would have special responsibility to provide information and professional support to a number of divisions as a contribution both to patient care evaluation and to other divisional functions.

Chapter 5 **The Medical Advisory Structure in the Area**

5.1 Health Boards will be the Secretary of State's principal agents in administering the health service in their area. The formation and function of Health Boards have been discussed in paragraphs 2.2 and 2.3 and the derivation of the Area Medical Committees in paragraph 2.6. The significance of the responsibilities of Health Boards in the planning and management of the health service makes it of the utmost importance that the MAS which complements Health Boards should be both competent and effective.

5.2 The right to advise the Health Board and to be consulted by it will belong to the Area Medical Committee. The MAS within the area should therefore be centred on the Area Medical Committee which must itself be representative of the profession in the area and thus be able to seek recognition by the Secretary of State.

5.3 The MAS in the area must fulfil a number of requirements and should be conceived as an organisation built around the Area Medical Committee and operating through it. The MAS must provide a consultative framework to enable each of the specialties to undertake a continuing assessment and evaluation of its work in the area and to look at future needs. In addition, however, some specialties which are small and have wide geographical responsibilities may need to find within the area structure a forum for consideration of some of the planning problems which larger specialties are able to resolve within the district. The Health Boards will replace Executive Councils as the authorities with which general practitioners will be in contractual relationship, and the MAS at Health Board level will require to take over and exercise the statutory functions at present carried out by the Local Medical Committee.

5.4 The function of the Area Medical Committee itself will be to take a broad view of health planning and it should be assisted in detailed work by sub-committees. An Area Medical Committee may with the approval of the Health Board delegate any function, with or without restrictions or conditions, to sub-committees. The details of the sub-committee structure may vary from one area to another and will depend to some extent on the size of the area, but in each area one sub-committee should be a general practice sub-committee to which the Area Medical Committee could delegate functions presently carried out by Local Medical Committees. This sub-committee would require to have a membership broadly representative of the general practitioners in the area.

5.5 Health Boards should look to their Area Medical Committees as the source of collective advice and considered opinion from the medical staff in their areas. The Chairmen of Area Medical Committees should have the opportunity to attend meetings of Health Boards to convey the views of their committee.

5.6 The Area Medical Committee, in common with other parts of the MAS, will be an integral part of the health service and it should be expected to develop an intimate working relationship with the Health Board. This will be greatly assisted if the Area Medical Committee is serviced by the Health Board and if community medicine specialists give professional support to the Area Medical Committee and its sub-committees.

Membership of Area Medical Committees and their Sub-committees

5.7 The way in which membership of Area Medical Committees should be derived will depend to some extent on the size of the area but some general points can be made:

i Size of Area Medical Committee

Some limit should be put on the size of the Committees if they are to be effective. A membership of 15 might be sufficient for all but the largest areas.

ii Balance Between Specialties

Given that the function of the Area Medical Committee is to take a broad view and that specialty considerations will be the responsibility of sub-committees, it may not be necessary to carry the balance between specialties to extremes, but roughly equal numbers will be needed between hospital based practitioners and those concerned with primary care.

iii Geographical Balance

In an area with several districts it will be necessary to secure a reasonable balance of membership between the districts.

iv Representation of Universities

We have already expressed the hope that university staff will be active in the MAS, and if this is the case, some will be likely in the normal course of events to become members of Area Medical Committees in those areas which have teaching hospitals. Nevertheless we think that there is a case for nominating one or two members to such Area Medical Committees specifically to represent the university concerned and suggest that this is a matter which might be put to University Liaison Committees for advice.

v Junior Doctors

Provision must be made for the representation by direct nomination of doctors in training.

vi Tenure of Office

This has to be considered not only in relation to the Area Medical Committee but also because of the implications it will have for the district MAS in contributing members to the area, and for the MAS at national level in deriving members from the area. It would seem that uniform tenure of office throughout the MAS would have great practical advantages. The normal term of office of members should be 4 years, and some limitation on the number of consecutive terms in any one office might be considered.

5.8 In a small area which is not divided into districts, there should be little practical difficulty in deriving an Area Medical Committee. This would in effect be the same as the District Medical Committee formed on the lines discussed in the preceding Chapter. In areas with two or more districts the mechanism for the appointment of the Area Medical Committee must of necessity be more complex.

5.9 Even in areas with two districts, it will not be possible to involve the chairmen of all divisions in both districts in the membership of Area Medical Committees, except at the price of creating a very large committee. We think this would be undesirable and some other means of deriving the membership should be sought. It would be important in maintaining co-ordination and communication between the Area and District Medical Committees that the Chairmen of the two District Medical Committees should be members of the Area Medical Committee and some formula such as the addition of two hospital based practitioners and two primary care practitioners from each district might be used to provide further members. These members could be appointed by the appropriate District Medical Committees or directly elected by the staff concerned. Ten members (the two district medical committee chairmen and four others from each district) would be appointed in this way, and other members would no doubt be added to represent junior doctors and other special interests if this were considered desirable.

5.10 In areas with more than two districts, the problem in obtaining a well balanced representative Area Medical Committee of reasonable size will be greater. It would probably be considered desirable that the Chairmen of the District Medical Committees should be members of the Area Medical Committees but the addition of two hospital specialists and two primary care specialists from each district along with representatives of universities and junior doctors would result in the formation of very large committees in some areas. If this is not acceptable, then the number of representatives from each district may have to be reduced.

Appointment of Sub-committees

5.11 The General Practice Sub-Committee should assume many of the functions at present carried out by Local Medical Committees and will require a membership which will give good representation of general practitioners in the area. This will involve inclusion of general practitioners who are not members of the Area Medical Committee.

5.12 The other sub-committees would principally be those appointed to deal with specialty matters, and it is important that they should enjoy the confidence of practitioners in the specialty concerned. For this reason, it is desirable that a significant proportion of the membership should be derived directly from the appropriate divisions. Where larger specialties are concerned, the area specialty sub-committee should include the chairmen of the appropriate divisions in each of the districts. Further members might be added to take account of related interests or of academic and research needs. In the case of smaller specialties, it may well happen that none of those who are involved in their practice hold the office of chairman of a division. Membership would therefore have to be derived from individual practitioners of the specialties in each district. The area sub-committees concerned with the smaller specialties will have an important responsibility in ensuring that the views of these smaller specialties are adequately presented to the parent committee. In addition to its normal communications with its own Area Medical Committee, a specialist sub-committee may need to develop lines of communication with specialist sub-committees in other areas or with the appropriate national sub-committee. The advantages in favour of one or other of these courses will differ from specialty to specialty.

Interim Arrangements

5.13 Health Boards will be appointed in 'shadow' form in the very near future and will require to make important management decisions before assuming responsibility for the running of the health service. Decisions on the division of areas into districts for management purposes will be taken during this period. It is important that the medical staff who work in an area and who will transfer to the Health Board on the appointed day should be able to present their views to the 'shadow' Board. It will not be possible to appoint an Area Medical Committee on the lines proposed above until shortly before, or soon after, the appointed day, but we believe that the profession in each area should make an interim arrangement so that their views can be expressed during this important period in the establishment of the new organisation of the health service.

Multi-professional Approach in the Area

5.14 Local consultative committees (*eg* the Area Medical Committee) would normally be composed of a single profession but there is also a generally agreed need for a multi-professional approach at each level in the health service, covering a range of health service activities such as child health, geriatrics, mental health and scientific services. It is reasonable to expect that Health Boards, particularly in the larger areas, would look to the appropriate professional committees for assistance in identifying areas and subjects that would benefit from consideration by multi-professional committees, and for nomination of individuals to membership of them.

Chapter 6 **The Medical Advisory Structure and the Scottish Health Service Planning Council**

6.1 An important objective of the new arrangements is to achieve improved national review and planning of services.

6.2 Section 17 of the National Health Service (Scotland) Act 1972 provides for the formation for this purpose of a Scottish Health Service Planning Council, whose constitution and functions have already been mentioned in paragraph 2.5(*a*).

6.3 Planning of the health service cannot be successful without a continuing review of existing services and neither this review nor the planning itself is possible without the knowledge and experience of the professions engaged in the provision of health care. This knowledge and experience needs to be given a formal place within the central administrative arrangements and section 18 of the Act makes precisely this provision for the recognition in relationship to the Planning Council of committees which are representative of any, some or all of the health care professions.

6.4 The terms of the Act and of the discussion papers that preceded it are such as to enjoin on the medical profession the need to form such a committee which, we suggest, should be known as the National Medical Consultative Committee. As the central point of the MAS it would be a focus of communication between area committees and between specialist sub-committees as well as with the Planning Council, with which it would work in partnership. It would be expected not only to deal with questions referred to it by the Planning Council but also to take any initiative that appeared proper to it. Responsibility for creating the Committee rests with the profession: once the committee has been recognised its right to be consulted is established by the Act.

6.5 Such a Committee will need to be competent over a very wide range of activities so that it can speak with equal authority both on the current position in every branch of medicine and on probable developments whether of a general or of a highly specialised nature. Its interest, and that of the specialist sub-committees which we would expect it to appoint, must cover the assessment of priorities, the evaluation of patient care and the over or under use of resources. At the other end of the scale it may need to advise on the location of sophisticated specialist services or the adoption into routine use of developments resulting from research work.

6.6 Much of this activity will be dependent on the collection and interpretation of information either in the Committee itself or with outside assistance. A means which we strongly commend of ensuring the

availability of all relevant information would be for the profession to seek to have the Committee provided with secretarial and other supporting services in common with those of the Planning Council itself. This would in no way diminish the independent status of the Committee nor preclude the possibility of a joint secretariat from the profession and the Scottish Home and Health Department, and it would provide an invaluable link with the Department's own resources for data collection and analysis. The attendance of the chairman of the Committee as an assessor at Planning Council meetings is another important measure which should help to ensure adequate communication.

6.7 Many of the functions to be undertaken by the Planning Council will require co-operation amongst several health professions and a link with other related services such as the social work agencies. It seems likely that much of the preparatory work necessary for policy making will therefore be initiated by the Council setting up permanent or ad hoc 'programme' committees to deal with such fields as mental health, maternity services, geriatrics, trauma or environmental health. These committees are likely to be the points where the health professions collectively can bring the strongest influence to bear on national discussions; great importance therefore attaches to the ability of the medical profession to provide these committees with facts, advice and membership.

6.8 As a Sub-group of the Joint Working Party we clearly have no mandate either to prescribe a firm constitution for the National Medical Consultative Committee nor to take any direct initiative in setting it up. Our responsibility must be to suggest general principles and the form of constitution that would be compatible with the rest of the structure we have described, and to ensure that the need for action is made as widely known as possible.

6.9 We recommend that a body should be convened from professional sources for the purposes of agreeing a basis for the appointment of a National Medical Consultative Committee (possibly provisionally in the first instance) for which recognition could be sought. The formally constituted Committee could then itself review its structure and derivation, perhaps after some experience had been gained of the working of the MAS as a whole.

6.10 We believe that the profession would regard the convening of such a meeting as a proper responsibility for the British Medical Association in Scotland. We recommend that the Association with the possible co-operation of the Scottish Home and Health Department should take steps to bring together representatives of all professional bodies with a significant interest in the establishment of the National Committee. The organisations to be involved should include the Scottish General Medical Services Committee, the Scottish Committee for Hospital Medical Services, the Public Health Committee (Scotland), the Royal Colleges and Faculties, Universities in Scotland with Medical Faculties and the Hospital Junior Staff Group Council (Scotland).

6.11 The National Medical Consultative Committee should be based on the following principles and provisions:

(i) It must be representative of the medical profession in order to be recognised by the Secretary of State (NHS (Scotland) Act 1972, section 18(i)).

(ii) Professional teaching interests in relation to the medical profession should be represented by such members appointed in such manner as may be prescribed (section 18(ii) of the Act).

(iii) The sources of membership must be in proper balance. For the reasons that are set out in Chapter 3 equal weight should be given to general and to hospital practice and in addition geographical, specialty and educational interests must all be represented in proper proportion.

(iv) There should be a continuous chain of communication from periphery to centre. It is important that the MAS above area level should not be separate from the organisation at that level (*Doctors in an Integrated Health Service* para 157).

(v) The Committee should take advantage of the powers to appoint sub-committees and to add to them members who need not necessarily be members of the parent Committee itself (section 18(vii) of the Act).

(vi) Doctors in training, whether in hospital or general practice, should be specifically represented.

6.12 Our own discussions suggest that it may be easy to find agreement on these principles, but that their effective translation into a practicable constitution may require considerable study. Direct election from every geographical, professional and educational 'constituency' would produce a committee of unmanageable size and variable balance, but with the advantage of good vertical integration and direct derivation from its various sources. Selection from amongst a list of elected nominees could produce a broadly derived committee of small size, but at the risk of one or other legitimate interest being, or appearing to be, under-represented, or of a very heavy responsibility being placed on individual members called on to represent a whole range of medical activities.

6.13 The constituting body mentioned in paragraph 6.9 may wish to give some consideration to these points but one solution that found majority support in the Sub-group, and which is described below, may provide a model embodying the principles set out in paragraph 6.11 in a way that should be easily realisable in practice.

6.14 'Constituencies' might be formed from each of the groups principally involved. The final selection of the Committee itself and the maintenance of the necessary balance within it might be the responsibility of the 15 Chairmen of Area Medical Committees acting jointly within broad guidelines to be laid down.

6.15 Each Area Medical Committee might be invited to nominate 3 candidates, of whom one would be selected by the group of 15 Chairmen for membership of the National Medical Consultative Committee. In putting forward their nominations Area Medical Committees would be expected to avoid selecting all three either from general practitioners or from hospital practitioners. Thus it would be possible for the Chairmen of Area Medical Committees, in making their selection, to ensure that there was an approximate balance between members from general practice and members from hospital practice and, within the latter group, to ensure a measure of spread between specialties.

6.16 Another group of members might be derived from the profession acting through its Royal Colleges and specialist Faculties to represent the major areas of professional knowledge and experience. The number of members to be derived in this way might be approximately nine, and three nominations would be invited for each of these places.

6.17 A further six nominations of general practitioners, possibly made by the Scottish General Medical Services Committee, might be available as a pool from which appointments could be made in order to ensure an approximate balance between general practitioners and hospital practitioners.

6.18 Each of the Scottish Universities with a Faculty of Medicine might be invited to nominate three candidates, one of whom would be selected from each University for membership of the Committee.

6.19 The membership of the Committee would be completed by the appointment of two junior doctors, one from the hospital service and one from general practice.

6.20 It will be seen from the table that the maximum membership of the Committee under the system we suggest would be 36. If some members were nominated from more than one source and could represent more than one interest a satisfactory balance might be obtainable with a membership as small as 30. This is still a larger Committee than we should regard as ideal but we believe that it represents the lowest figure that is realistic under present circumstances.

Source	*No. of Nominees*	*No. to be selected for service on NMCC*
Area Medical Committees	15×3=45	15
Colleges and Faculties	9×3=27	9
Universities	4×3=12	4
Junior Doctors	1 Hospital, 1 GP = 2	2
		30
Balancing representation of general practitioners as required		up to 6
		TOTAL 30-36

Some implications for existing Advisory Bodies

6.21 The formation of the Scottish Health Service Planning Council and the provision in the NHS (Scotland) Act 1972 for the recognition of a National Medical Consultative Committee will inevitably have implications for some existing advisory bodies. One of the most important of these is the Scottish Health Service Scientific Council which has a responsibility to advise the Secretary of State. Without some change a situation could exist in which the Scientific Council would be isolated from the main advisory structure and its advice would be presented directly to the Secretary of State without prior consultation with the Scottish Health Service Planning Council. This would be unlikely to lead to the co-ordinated planning in which the Scientific Council would no doubt wish to participate.

6.22 This difficulty could be avoided if the Scientific Council were restructured as a Scientific Committee of the Planning Council with membership covering the same kind of interests as the present Scottish Health Services Scientific Council, and if there were adequate cross-representation between the Scientific Committee and the National Medical Consultative Committee. The Scientific Committee might well need to set up its own sub-committees to deal with the major sub-divisions within the scientific services.

6.23 Different considerations will arise with the Scottish Advisory Committee on Computers in the Health Service because of the relationship between the computer and information services. The future role of the Advisory Committee on Medical Research may be affected by the proposals in the recent White Paper *Framework for Government Research and Development* (Cmnd. 5046) but some linkage between it and the Medical Advisory Structure will be necessary.

6.24 A link with the Advisory Committee on Hospital Medical Establishments may also be needed.

6.25 We understand that it is the present intention that the Scottish Council for Postgraduate Medical Education should remain independent of the advisory machinery but some links between it and the Planning Council will be needed, at least to cover the exchange of information.

Chapter 7 Communications

7.1 Throughout this report we have referred to the need to establish and maintain good communications. Much of the responsibility for this will fall on chairmen of committees and on community medicine specialists.

Communications through Chairmen of MAS Committees

7.2 Chairmen in the MAS will have a clearly constituted role carrying a great deal more responsibility than any similar office has had in the past. The authority of chairmen will derive partly from their position as the elected representatives of their colleagues and partly from the much more formal recognition which all consultative committees set up under the National Health Service (Scotland) Act 1972 will enjoy.

7.3 The nature of the working relationship between committee chairmen and officials of Health Boards is to be deduced from the Act and from the guidance which has been issued by the Scottish Home and Health Department on future administrative arrangements in the health service. Chairmen will not be executive, as officers of health authorities will be. They will have no hierarchical position in the medical staffing structure, nor be accountable to Health Boards in any strict legal sense for their actions as chairmen. Their position vis-a-vis the administrative structure will in fact be strengthened immensely by their independence from it and by their dependence on the confidence of their colleagues.

7.4 A chairman should be looked upon, therefore, as an intermediary, as a channel of communication, and as being responsible for interpreting medical opinion to the administration and administrative opinion to the medical staff. The chairman should have a continuing relationship with the appropriate executive group but should not be the only doctor with access to it. He should have the right and the duty also to bring to the group other members of staff who may be in a position to speak with greater authority on a particular subject. Any such access should always be with the knowledge of his committee. In cases of controversy, the chairman should report the majority view but should also make known any large minority opinion and present the supporting arguments for both viewpoints. He should be able to delegate specific responsibilities, either regularly or on an ad hoc basis, but always within a known framework and with the approval of the committee.

7.5 In general the office of chairman should be looked upon as a means whereby a wide range of subjects can be effectively covered and a large number of people be available for discussions, although discussion groups should always be small. The concept of chairman is not compatible with the rigid allocation of responsibilities inherent in the post of consultant in administrative charge. This type of post should, therefore, now be abolished.

Communications through Community Medicine Specialists

7.6 The full range of functions of specialists in community medicine and the internal organisation of the specialty are not the concern of this sub-group. Individual community medicine specialists, however, will be closely and continuously involved in every activity of the MAS in a way which can already be seen to be important, and is likely to evolve further in the next few years.

7.7 Within divisions, including divisions of general practice, community medicine specialists will be concerned with such matters as identifying populations at risk, forecasting expected trends in relation to particular diseases, and looking for areas of deficiency or for underused or overused resources. This represents a large additional need for epidemiological and similar skills compared with the relatively small use that is currently made of them in relation to patient care. For the majority of clinicians, divisions will probably remain the institutions through which they can most readily put their day to day responsibilities into perspective against the background of community needs. This, therefore, is the point where clinical and community specialists can most easily make common cause.

7.8 In their relationship with divisions concerned with specialist and primary care services, specialists in community medicine should not merely be the source of epidemiological and other advice; they should be in a position to put forward their own interpretation of community needs and to influence divisions in their decisions about the allocation of resources and the assessment of priorities. Good working relations at divisional level would contribute greatly to the appreciation by clinicians of the important, and to some extent untried, role which community medicine will have to play throughout the service.

7.9 These functions will be the more important as integration proceeds. There is likely then to be a gradual shift away from present institution- and specialist-based concepts towards thinking in terms of a federation of all services for defined populations within areas and in large districts. At all levels community medicine specialists will come into particularly close contact with the elected chairmen of medical committees. The development of good working relationships at these points is probably one of the most important factors in determining the use that is made of the new opportunities which integration will bring.

Chapter 8 **The Advisory Structure and Patient Care—The need for action**

8.1 Underlying the whole of this report is the conviction that changes in the health service which might at first sight appear to be purely administrative will in fact have a major impact on patient care. It is true that the quality of the relationship between the doctor and his patients is independent of the administrative framework within which it may be organised: it is equally true that the quality of care that can be offered within given limits of resources is dependent upon the way in which the resources are deployed.

8.2 An accurate tailoring of resources to needs is obviously impossible if the needs are not fully evaluated and clearly expressed. A change is now in train which will fundamentally alter the interplay of medical and executive authority, and introduce new channels of communication: it is inescapable that it will have a profound and increasing effect on the profession's ability to meet the demands that are made on it.

8.3 We believe therefore that, although April 1974 may bring little change in the day to day work of most doctors, it will mark the beginning of a period highly significant for the future. The quality of the care that will be available in Scotland over the next 20 years, and the capacity of the health service to incorporate the best of new ideas and methods, will depend in large measure upon the vision and sense of purpose that are brought to bear now on the creation of the new advisory structure. This is a responsibility which is placed equally upon every doctor now practising in Scotland.

8.4 Those who feel that more extensive reading will assist discussion will find it in several sources, and perhaps principally in Chapter VII of *Doctors in an Integrated Health Service* (1971) a copy of which was sent to all doctors in Scotland. We believe, however, that the present situation itself provides incentive and challenge enough to ensure that the initiative that is expected from the profession will be forthcoming.

8.5 In the first instance, the fullest possible participation is needed in discussions which will have to cover a very wide field. The first objective must be to ensure that the importance of the impending change is understood. From this, there should develop an agreed view on the ways in which the profession should meet the new opportunities that present themselves, and on the kind of structure that should be created to enable these opportunities to be effectively grasped. Where, as is inevitable,

there are conflicts of professional interest, we believe these will always be capable of resolution if reference is made to the over-riding consideration of patient care. Some doctors, obviously, will direct their principal attention to the local scene, and others to the national one: but all should be able to see, within the perspective of steadily rising standards of medical care, the possibility of increasing their professional effectiveness.

8.6 We hope that this report will provide clear enough guidance to be a stimulus to these discussions and a realistic basis for action, while still leaving the way open for the very considerable variations that will be required to meet differing local needs and changing circumstances in the future.

DIAGRAMS

DIAGRAM "A"

THIS DIAGRAM IS TO BE INTERPRETED BY REFERENCE TO CHAPTERS 4 AND 5 OF THE TEXT

DIVISIONS AND SPECIALTIES HAVE BEEN NAMED FOR ILLUSTRATIVE PURPOSES ONLY

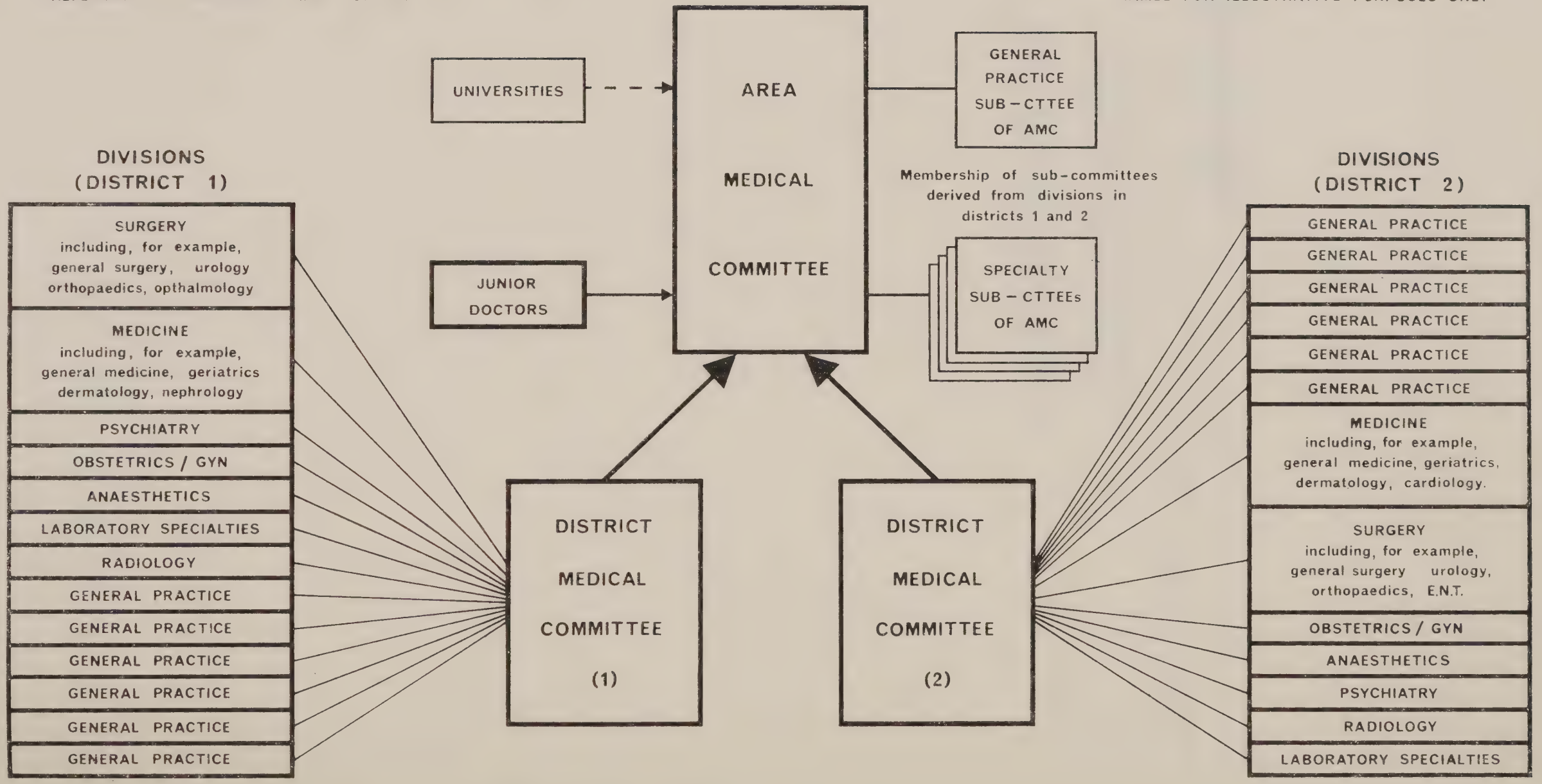
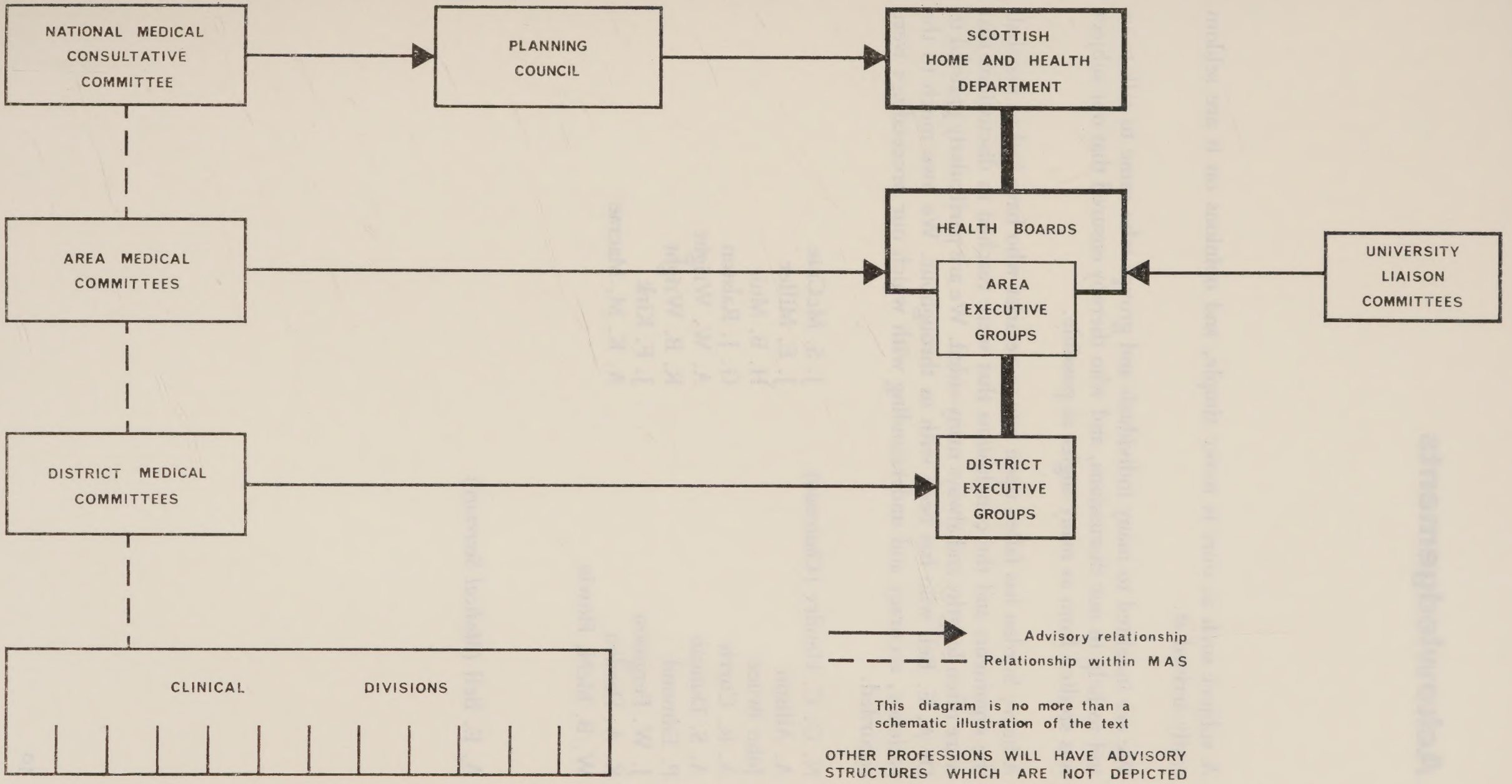


DIAGRAM B



This diagram is no more than a schematic illustration of the text

OTHER PROFESSIONS WILL HAVE ADVISORY STRUCTURES WHICH ARE NOT DEPICTED

Ackowledgements

A subject such as ours is never simple, and opinions on it are seldom easily arrived at.

We are indebted to many individuals and groups who came to talk to us and to help in our discussions, and who thereby ensured that our subject was studied from as many angles as possible.

A heavy burden has fallen upon our secretariat who have had to marshall the arguments and the conclusions that were reached in discussions that were often lengthy and always many-sided. We are particularly grateful to Dr A. E. Bell who has been with us throughout. We owe much to the patience, accuracy and understanding with which our proceedings were recorded.

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